EXHIBIT I

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory MARYLAND

CASE MANAGEMENT SERVICES
FOR CHILDREN DIVERTED/RETURNED FROM OUT-OF-STATE RESIDENTIAL TREATMENT FACILITIES

A. Target Group:
See Attached

B. Areas of State in which Services Will Be Provided:
_____Entire State
__X__Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide):

Baltimore City, Anne Arundel, Calvert, Caroline, Cecil, Dorchester, Garrett, Harford, Kent, Montgomery, Prince George's, Queen Anne's, Talbot, Worcester Counties.

C. Comparability of Services:
_____Services are provided in accordance with §1902(a)(10)(B) of the Act.
__X__Services are not comparable in amount, duration and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B).

D. Definition of Services:
See Attached

E. Qualifications of Providers:
See Attached

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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A. Target Group:

An individual who is certified for and is receiving Maryland's Medical Assistance benefits and is determined by the Department of Health and Mental Hygiene or its designee to be eligible for Case Management for Children Diverted/Returned from Out-of-State Residential Treatment Facilities if the recipient is enrolled through the Local Coordinating Council in a Medicaid home and community based services waiver under Section 1915(c) of Title XIX of the Social Security Act, or:

1. Is in a federal eligibility category for Maryland's Medical Assistance Program according to COMAR 10.09.24;
2. Is less than 21 years old;
3. Is an individual who:
   a. Has emotional, behavioral, or mental disorders or is developmentally disabled or multi-handicapped as verified by the Local Coordinating Council (LCC), and
   b. May have learning impairment, attention deficit disorder, or conduct disorder conditions as confirmed by the LCC;
4. Has been determined by the LCC to:
   a. Be eligible for an out-of-state residential placement,
   b. Be suitable for alternative placement in community-based services, and
   c. Require intensive interagency case management services;
5. Is being:
   a. Diverted from an out-of-state residential placement which is funded by Maryland, and is eligible to remain in the community in the least restrictive setting, or
   b. Returned from an out-of-state residential placement which is funded by Maryland, and is eligible for community-based services as an alternative to an out-of-state residential placement;
6. Is under the custody of or is receiving care funded by a public human service agency;
7. Resided at the time of the decision to place the recipient in the out-of-state residential placement in Baltimore City or Anne Arundel, Calvert, Caroline, Cecil, Dorchester, Garrett, Harford, Kent, Montgomery, Prince George's, Queen Anne's, Talbot or Worcester Counties;
8. Has a current, documentable need as determined by the LCC for a case manager's assistance with:
   a. Transitioning from an out-of-state residential placement to a community placement,
   b. Identifying and accessing needed services,
   c. Handling crisis situations,
   d. Modifying service delivery, or
   e. Sustaining involvement with needed services;
9. Is not receiving similar case management services under § 1915(c) or (g) of Title XIX of the Social Security Act; and

10. Elects, or the recipient's representative elects on the recipient's behalf, to receive the services available under this chapter.

D. Definition of Services:

Maryland Medical Assistance shall reimburse for the following services when they have been documented as necessary and appropriate:

Initial Assessment and Reassessment

1. An assessment or a reassessment of a participant's status and service needs is conducted by the case manager or case management supervisor and shall include:
   a. A plan for the participant's reintegration into the community setting or diversion from a residential treatment facility;
   b. An evaluation, when appropriate, of the participant's family, home, and community environment;
   c. Interviews with any residential placement service providers and with staff of the relevant public human service agencies;
   d. Review of medical and other pertinent records with the participant's or the participant's representative's written consent;
   e. An analysis of the participant's social, educational, familial, cultural, medical, developmental, legal, vocational, psychiatric, economic, and other needs;
   f. A collection of relevant input, as appropriate, from:
      (1) The participant or the participant's representative,
      (2) The participant's family or other caregiver, and
      (3) Community service providers; and
   g. An evaluation, when a reassessment is being performed, of the:
      (1) Appropriateness and effectiveness of service delivery, and
      (2) Participant's satisfaction with the Interagency Service Plan, service providers, and service delivery.
2. An initial assessment of a participant shall be completed before the development of an Interagency Service Plan.
3. A reassessment of a participant shall occur at least once and not more than six times in a 12-month period, to ensure that the ISP consistently addresses the participant's needs.
4. Each assessment or reassessment shall be:
   a. Reviewed by the Local Coordinating Council as the Department's designee;
   b. Approved by a case management supervisor;
   c. Culturally appropriate by addressing:

(1) Level of ethnic identity,
(2) Current socioeconomic status,
(3) Beliefs, habits, and customs,
(4) Language and communication process,
(5) Values of orientation,
(6) Views about ethnicity,
(7) Cultural health beliefs,
(8) Use of informal network, and
(9) Influence of religion or spirituality on the belief system and behavior patterns; and

d. Focused on the participant's strengths rather than deficits.

5. Reassessments may be used in planning for a participant's termination from the covered services, based on the participant's:

a. Ability to reintegrate into the community; and
b. Reduced risk of being placed in a more restrictive setting.

Interagency Service Plan Development or Revision

1. Interagency Service Plan Development or Revision shall:

a. Be developed after the initial assessment has been completed and be revised as necessary after each reassessment;
b. Be developed and revised by an interagency team, in consultation with the Local Coordinating Council;
c. Include the participant's Individualized Educational Plan for the community-based educational program, if the participant is eligible for special education services;
d. Be completed in the format approved by the Medical Assistance Program;
e. Be signed by the participant or the participant's representative indicating consent, cooperation, and agreement;
f. Document the participant's interagency service needs and inability to access independently the needed services; and
g. Identify tasks which relate to reducing the risk for the participant's being placed in a more restrictive setting.

2. The Interagency Service Plan shall include:

a. The programs and interagency services needed by the participant and recommended by the case manager, for the purpose of assisting the participant to gain access to needed services;
b. The type, frequency, and duration of needed services, to include both what is needed and what is available;
c. An identification of the community-based resources potentially available to meet the participant's needs, including informal supports available from family, friends, community organizations, and other sources;
d. The participant's wishes and preferences;
e. The responsibilities and expectations of the participant and the participant's family members; and
f. The care limitations and precautions.

Ongoing Case Management

Ongoing Case Management is the provider's intensive, monthly provision of case management services to a participant. The covered services shall include as necessary:

1. Implementing the Interagency Service Plan or revision by:
   a. Advising the participant or the participant's representative about the available services and service providers;
   b. Assisting the participant or the participant's representative in choosing among the available service providers;
   c. Coordinating implementation of the Interagency Service Plan with the participant's family, other caregivers, and service providers, as appropriate;
   d. Discussing with service providers the services needed and available for the participant;
   e. Providing the participant and the participant's representative, family, or other caregiver with any necessary information concerning how to access and use the services recommended in the Interagency Service Plan, including Medical Assistance and other government entitlement programs, informal resources and other support programs and resources; and
   f. Acting as the participant's advocate and assisting the participant, as necessary, in gaining access to services recommended in the Interagency Service Plan by:
      (1) Making referrals to and arrangements with service providers selected by the participant or the participant's representative, and
      (2) Assisting the participant in forming linkages with chosen resources;
2. Following up promptly after the participant's referral to service providers and then monitoring the participant's status and the service delivery on an ongoing basis to determine whether the services are:
   a. Received in accordance with the Interagency Service Plan;
   b. Appropriate in quantity and quality;
   c. Provided in the least intrusive and least restrictive manner possible; and
   d. In accordance with the goals stated in the Interagency Service Plan;
3. Acting as a point of contact for the participant, to ensure efficient coordination among multiple service providers and a continuum of care;
4. Coordinating service provision, identifying obstacles which impede implementation of the participant's Interagency Service Plan and utilization of services, and resolving conflict between service

providers or between a service provider and the participant, participant's representative, family member, or other caregiver.

5. Making any arrangements necessary to assist the participant in gaining access to needed services by:
   a. Arranging for transportation needed by the participant;
   b. Assisting with scheduling appointments for the participant with service providers;
   c. Reminding the participant of appointments; and
   d. Assisting with the removal of any other barriers to the participant's receipt of services;
6. Crisis intervention by providing information and assistance to help the participant gain access to needed services on an emergency basis when immediate intervention is necessary;
7. Maintaining contact with the participant, the participant's representative, and service providers through:
   a. Regular telephone contact,
   b. Face-to-face visits with the participant in the home or any location that is preferred by the participant in the community, as specified on the Interagency Service Plan; and
   c. Regular review of relevant records with the participant's or the participant's representative's written consent; and
8. Monitoring on an ongoing basis the:
   a. Participant's status and need for services;
   b. Appropriateness and effectiveness of service delivery;
   c. Participant's progress in meeting the most recent goals established in the Interagency Service Plan;
   d. Participant's satisfaction with the Interagency Service Plan, service providers, and service delivery;
   e. Need for a reassessment or for minor changes to be made in the Interagency Service Plan or in service delivery; and
9. Planning termination services for the participant to remain in the community-based delivery system when the participant no longer qualifies for the services covered.

E. Qualifications of Providers:

1. General requirements for participation in the Medical Assistance Program are that a provider shall meet all the conditions for participation as set forth in COMAR 10.09.36.03.
2. Specific requirements for participation in the Medical Assistance Program as a provider of Case Management for Children Diverted/Returned from Out-of-State Residential Treatment Facilities are that a provider shall:

a. Be approved for participation by the Department of Health and Mental Hygiene and have a current provider agreement in effect with the Medical Assistance Program;

b. Have a written implementation plan approved by the Medical Assistance Program for the services covered under this chapter, that specifies the provider's procedures and practices for accomplishing the following minimum objectives:

(1) Services will be provided in the least restrictive setting appropriate to meet the participant's needs,

(2) Services will be tailored to meet the participant's needs,

(3) Services will be performed in the location and by the providers preferred by the participant,

(4) Service plans will be developed and approved through a multidisciplinary process, and

(5) Services will be rendered in accordance with the other requirements in the regulations, COMAR 10.09.49;

c. Agree to provide covered case management services that are consistent with the participants' goals and to meet the participants' interagency case management needs;

d. Protect the rights and confidentiality of the participants;

e. Encourage the participant and the participant's representative to be active in the case management process;

f. Facilitate and encourage participants' transition into the community-based service delivery system;

g. Establish linkages with public and private service agencies to obtain service information pertaining to the participant, while ensuring the participant's continuity of care and requirements relating to confidentiality;

h. Require all case managers and case management supervisors to complete satisfactorily the ongoing training offerings approved by the Medical Assistance Program relative to integrated service delivery standards, to assure quality care;

i. Agree to work with and accept technical assistance from the Program's designee;

j. Agree to work within the current State guidelines approved by the Medical Assistance Program regarding interagency family preservation services;

k. Demonstrate capability as a provider by having a commitment to family-centered care, as well as experience in providing services through an interagency case management model to children being diverted or returned from out-of-State residential placements,

l. Employ as case management supervisors those individuals who have:

(1) A:
(a) Social work license, or
(b) Master's degree in social work or a related field; and

(2) At least 3 years of experience in coordination of care, team planning, networking with multiple public and private agencies, supervision, and crisis intervention;

m. Employ as case managers those individuals who:

(1) Have a degree in a health, human services, or related field at the:

(a) Bachelor's level as well as at least 1 year of experience in coordination of care, team planning, networking with multiple public and private agencies, and crisis intervention, or

(b) Associate's level as well as at least 3 years of experience in coordination of care, team planning, networking with multiple public and private agencies, and crisis intervention; and

(2) Have work experience with children similar to those receiving this case management service;

n. Agree to be available to participants and their families for 24 hours a day, 7 days a week and on a nonscheduled basis as necessary for problem resolution and crisis management;

o. Provide information and maintain files on participants as required by the Medical Assistance Program;

p. Agree to:

(1) Comply with the Medical Assistance Program's fiscal and other reporting requirements; and

(2) Submit reports in the manner specified by the Medical Assistance Program ; and

q. Ensure that the necessary mechanisms are in place to link the provider's case management records to the automated information system required for this service by the Medical Assistance Program.

r. Agree to provide covered services in accordance with the Program's policies and procedures.